Print Reset Form

Instructions for Completion

Fill-In Instructions

# INSURER'S NOTICE OF NAME OR ADDRESS CHANGE

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
P O Box 30016, Lansing, Michigan 48909

*INSTRUCTIONS: See reverse side*

## Section A

| Employer Federal ID Number<br>**Click Here to Start** | Name of Business |
|---|---|
| Policy Number | |

## Section B

| Former Name/Address of Business | Current Name/Address of Business |
|---|---|
| Name of Business | Name of Business |
| Address (Street Number and Name) | Address (Street Number and Name) |
| City, State ZIP Code | City, State ZIP Code |
| Effective Date of Change | |

## Section C

| Please list below additional names and/or addresses for the Federal ID Number listed in Section A. | |
|---|---|
| Name of Business | Name of Business |
| Address (Street Number and Name) | Address (Street Number and Name) |
| City, State ZIP Code | City, State ZIP Code |
| Effective Date of Change | Effective Date of Change |
| Reason for Change | Reason for Change |
| Name of Business | Name of Business |
| Address (Street Number and Name) | Address (Street Number and Name) |
| City, State ZIP Code | City, State ZIP Code |
| Effective Date of Change | Effective Date of Change |
| Reason for Change | Reason for Change |

## Section D

| Name of Insurance Company | | | |
|---|---|---|---|
| NAIC Carrier ID Number (5 digits) | Group ID Number (4 digits) | ZIP Code of Issuing Office | Telephone Number |
| Authorized Signature | | | Date |

| | |
|---|---|
| Authority: | Workers' Disability Compensation Act of 1969, 418.625, Rule 408.41 |
| Completion: | Mandatory |
| Penalty: | Failure to file is punishable under MCLA 418.631 |

*Purpose of Form BWC-403*

To notify the Michigan Bureau of Workers' Disability Compensation of a name and/or address change of an employer. (Effective April 1, 1994, this will replace the procedure of filing a Form 401 and then a Form 400 showing a name change. Do not file a Form 401 terminating the old name.)

To notify the bureau of an addition or deletion of a division of the employer.

To notify the bureau of a name or address change of a division of an employer.

*Instructions for Completion:*

## Section A

| | |
|---|---|
| Employer Federal Identification Number: | Enter the employer's Federal Identification Number. This is a 9-digit number. If an individual (sole proprietor) does not have a Federal Identification Number, the Social Security Number of the individual will be accepted. |
| Name of Business: | Enter complete name of business, including assumed name. |
| Policy Number: | Complete number. |

## Section B

This section will be used to change the name and/or address of the employer. If used for a name change, this section must include the previous name of the employer and the new name of the employer.

| | |
|---|---|
| Name of Business: | Enter complete name of the employer. |
| Address: | The complete address of the business, including city, state and ZIP code, must be identified. Use street address, not post office box number. |
| Effective Date of Change: | Date that the name and/or address change is effective. |

## Section C

This section will allow for the addition, deletion, change of name, or change of address of a division. A division is an operation of the employer that operates under the same Federal Identification Number but under an assumed name. If used for a name change to a division, then this section must include previous name of the employer and the new name of the employer.

| | |
|---|---|
| Name: | Enter the complete name of the division. |
| Address: | The complete address of the business, including city, state, and ZIP code, must be identified. Use street address, not post office box number. |
| Effective Date of Change: | The date that the addition, deletion, or change of name and/or address is effective. |
| Reason for Change: | Addition of a division, deletion of division; i.e., due to sale of division, division no longer in business, etc.; or change; i.e., name change, address change, etc. |

## Section D

This section will identify the insurance company making the change.

| | |
|---|---|
| Name of Insurance Company: | Complete name of insurance company. |
| NAIC Carrier ID Number: | National Association of Insurance Commissioners' (NAIC) ID number (5 digits) |
| Group ID Number: | Insurance company group number (4 digits) |
| Telephone Number: | Telephone number of office filing the form. |
| ZIP Code of Issuing Office: | Show the complete ZIP code for the insurance company office issuing this form. |
| Authorized Signature: | Must have an original signature in black or blue ink. Typed signature is not acceptable. Include the date the form was signed. |

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| Form # | BWC-403 | Form Name: | Insurer's Notice of Issuance of Policy |
|---|---|---|---|

**Instructions:**

**Completing the Form:**

- ✔ Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.
- ✔ Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.
- ✔ To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.
- ✔ Press Tab to accept the field change and go to the next field, or
  Press Shift + Tab to accept the field change and go to the previous field.
- ✔ Use your mouse to select an area of the form that is not inside a form field before printing your form.
- ✔ To print the form, be sure to use the printer button on the Acrobat toolbar menu instead of your web browser's print function. You may need to select the “Print as image” option in the print dialog box to print the completed form.

**NOTE:** Please complete all date fields with the **MM/DD/YYYY** format.

**How to Submit This Form:**

- ✔ Print the completed form
- ✔ Sign the form
- ✔ Make 1 copy for your records
- ✔ Send the original of the signed Form 403 to:

**Bureau of Workers’ Disability Compensation**
**P O Box 30016**
**Lansing MI 48909**